FOR OHF USE

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2002
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2002)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0031765

Facility Name: BRIAR PLACE LTD.

Address: 6800 W JOLIET ROAD (Number) INDIAN HEAD PK (City) 60525 (Zip Code)

County: COOK

Telephone Number: (708) 246-8500 **Fax #** (708) 246-0086

IDPA ID Number: 363472799001

Date of Initial License for Current Owners: 11/01/86

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Steve Lavenda **Telephone Number:** (847) 236 - 1111

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/02 to 12/31/02 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)

(Type or Print Name) _____

(Title) _____

Paid Preparer

(Signed) See Accountants' Compilation Report Attached (Date)

(Print Name and Title) Edward Slack, CPA

(Firm Name & Address) Frost, Ruttenberg & Rothblatt, P.C.
111 Pfingsten Road, Suite 300 Deerfield, IL 60015

(Telephone) (847) 236-1111 Fax # (847) 236-1155

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number BRIAR PLACE LTD. # 0031765 Report Period Beginning: 01/01/02 Ending: 12/31/02

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	88	Skilled (SNF)	88	32,120	1
2		Skilled Pediatric (SNF/PED)			2
3	144	Intermediate (ICF)	144	52,560	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	232	TOTALS	232	84,680	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	23,904	1,350	5,115	30,369	8
9	SNF/PED					9
10	ICF	46,401	2,742	381	49,524	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	70,305	4,092	5,496	79,893	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 94.35%

D. How many bed-hold days during this year were paid by Public Aid?
1,293 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 11/1/86

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 11/1/86 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 20 and days of care provided 1,577

Medicare Intermediary AdminaStar Federal

IV. ACCOUNTING BASIS

ACCRUAL	MODIFIED CASH*	CASH*
[X]	[ ]	[ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/02 Fiscal Year: 12/31/02

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number BRIAR PLACE LTD. # 0031765 Report Period Beginning: 01/01/02 Ending: 12/31/02

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	320,397	38,600	19,529	378,526		378,526	(10,506)	368,020			1
2	Food Purchase		290,891		290,891		290,891	1,692	292,583			2
3	Housekeeping	206,120	42,121		248,241		248,241	(864)	247,377			3
4	Laundry	90,809	26,116		116,925		116,925		116,925			4
5	Heat and Other Utilities			203,495	203,495		203,495	2,068	205,563			5
6	Maintenance	176,392		105,897	282,289		282,289	6,442	288,731			6
7	Other (specify):*							1,892	1,892			7
8	**TOTAL General Services**	793,718	397,728	328,921	1,520,367		1,520,367	724	1,521,091			8
	B. Health Care and Programs											
9	Medical Director			8,250	8,250		8,250		8,250			9
10	Nursing and Medical Records	1,880,927	169,460	103,149	2,153,536		2,153,536	(104,517)	2,049,019			10
10a	Therapy	86,207	543	242	86,992		86,992	(5)	86,987			10a
11	Activities	125,955	8,223	5,973	140,151		140,151	(1,075)	139,076			11
12	Social Services	241,839		39,387	281,226		281,226	17	281,243			12
13	Nurse Aide Training											13
14	Program Transportation	47,834			47,834		47,834		47,834			14
15	Other (specify):*							18,429	18,429			15
16	**TOTAL Health Care and Programs**	2,382,762	178,226	157,001	2,717,989		2,717,989	(87,151)	2,630,838			16
	C. General Administration											
17	Administrative	26,544		79,643	106,187		106,187	42,000	148,187			17
18	Directors Fees											18
19	Professional Services			354,548	354,548		354,548	(309,161)	45,387			19
20	Dues, Fees, Subscriptions & Promotions			89,714	89,714		89,714	(42,280)	47,434			20
21	Clerical & General Office Expenses	54,747	15,740	62,650	133,137		133,137	130,891	264,028			21
22	Employee Benefits & Payroll Taxes			607,549	607,549		607,549	(30,194)	577,355			22
23	Inservice Training & Education			13,785	13,785		13,785		13,785			23
24	Travel and Seminar			845	845		845	1,336	2,181			24
25	Other Admin. Staff Transportation			30,249	30,249		30,249	(15,000)	15,249			25
26	Insurance-Prop.Liab.Malpractice			309,125	309,125		309,125	1,455	310,580			26
27	Other (specify):*							38,971	38,971			27
28	**TOTAL General Administration**	81,291	15,740	1,548,108	1,645,139		1,645,139	(181,982)	1,463,157			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	3,257,771	591,694	2,034,030	5,883,495		5,883,495	(268,409)	5,615,086			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number BRIAR PLACE LTD. #0031765 Report Period Beginning: 01/01/02 Ending: 12/31/02

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			129,396	129,396		129,396	243,145	372,541			30
31	Amortization of Pre-Op. & Org.			3,910	3,910		3,910	280	4,190			31
32	Interest			5,328	5,328		5,328	858,463	863,791			32
33	Real Estate Taxes			315,728	315,728		315,728	3,589	319,317			33
34	Rent-Facility & Grounds			942,530	942,530		942,530	(936,982)	5,548			34
35	Rent-Equipment & Vehicles			8,899	8,899		8,899	4,032	12,931			35
36	Other (specify):*											36
37	**TOTAL Ownership**			1,405,791	1,405,791		1,405,791	172,527	1,578,318			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		55,649	147,359	203,008		203,008	(7,808)	195,200			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			159,036	159,036		159,036	(32,016)	127,020			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		55,649	306,395	362,044		362,044	(39,824)	322,220			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,257,771	647,343	3,746,216	7,651,330		7,651,330	(135,705)	7,515,625			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number BRIAR PLACE LTD. # 0031765 Report Period Beginning: 01/01/02 Ending: 12/31/02

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(44,323)	30		9
10	Interest and Other Investment Income	(19,670)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(148)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(14,961)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(3,172)	20		28
29	Other-Attach Schedule	(163,792)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (246,065)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	110,360		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 110,360		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (135,705)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

BRIAR PLACE LTD.

ID# 0031765

Report Period Beginning: 01/01/02

Ending: 12/31/02

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	COPE	$ (4,139)	20	1
2	Revenue Misc Private	(772)	10	2
3	Jury Duty Income	(34)	10	3
4	Collection Expense	(1,717)	21	4
5	Bank Charges	(5,716)	21	5
6	Excess Bed Tax	(32,016)	42	6
7	Trust Fund Fee	(150)	20	7
8	Therapy Cost	(7,018)	39	8
9	Activity Supplies	(1,102)	11	9
10	Prior Year Legal Fees	(525)	19	10
11	VA Expense	(110,808)	10	11
12	Chamber Dues	(295)	20	12
13				13
14				14
15				15
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93				93
94				94
95				95
96				96
97				97
98				98
99				99
100				100
101	Total	(163,792)		101

STATE OF ILLINOIS

Summary A

Facility Name & ID Number BRIAR PLACE LTD. # 0031765 Report Period Beginning: 01/01/02 Ending: 12/31/02

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary					(2,166)	(3,156)	(5,184)					(10,506)	1
2	Food Purchase	(148)		(178)			2,018						1,692	2
3	Housekeeping							(864)					(864)	3
4	Laundry													4
5	Heat and Other Utilities			2,068									2,068	5
6	Maintenance			4,045		2,393	4						6,442	6
7	Other (specify):*				544	1,175	173						1,892	7
8	**TOTAL General Services**	(148)		5,935	544	1,402	(961)	(6,048)					724	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(111,114)		(49)	(4,633)	14,828	3	(3,552)					(104,517)	10
10a	Therapy				(5)								(5)	10a
11	Activities	(1,102)		3	24								(1,075)	11
12	Social Services					17							17	12
13	Nurse Aide Training													13
14	Program Transportation													14
15	Other (specify):*				16,386	2,043							18,429	15
16	**TOTAL Health Care and Programs**	(112,216)		(46)	11,772	16,888	3	(3,552)					(87,151)	16
	C. General Administration													
17	Administrative			487	21	41,424	68						42,000	17
18	Directors Fees													18
19	Professional Services	(525)		(308,772)			136						(309,161)	19
20	Fees, Subscriptions & Promotions	(22,717)		(19,570)			7						(42,280)	20
21	Clerical & General Office Expenses	(7,433)		19,949		118,277	98						130,891	21
22	Employee Benefits & Payroll Taxes				(30,194)								(30,194)	22
23	Inservice Training & Education													23
24	Travel and Seminar			1,190			146						1,336	24
25	Other Admin. Staff Transportation			(15,000)									(15,000)	25
26	Insurance-Prop.Liab.Malpractice			1,455									1,455	26
27	Other (specify):*				16,472	22,499							38,971	27
28	**TOTAL General Administration**	(30,675)		(320,261)	(13,701)	182,200	455						(181,982)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(143,039)		(314,372)	(1,385)	200,490	(503)	(9,600)					(268,409)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number BRIAR PLACE LTD. # 0031765 **Report Period Beginning:** 01/01/02 **Ending:** 12/31/02

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(44,323)	273,212	14,256									243,145	30
31	Amortization of Pre-Op. & Org.		280										280	31
32	Interest	(19,670)	862,928	15,205									858,463	32
33	Real Estate Taxes			3,589									3,589	33
34	Rent-Facility & Grounds		(942,530)	5,544			4						(936,982)	34
35	Rent-Equipment & Vehicles			4,027			5						4,032	35
36	Other (specify):*													36
37	**TOTAL Ownership**	(63,993)	193,890	42,621			9						172,527	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers	(7,018)					(790)						(7,808)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee	(32,016)											(32,016)	42
43	Other (specify):*													43
44	**TOTAL Special Cost Centers**	(39,034)					(790)						(39,824)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(246,065)	193,890	(271,751)	(1,385)	200,490	(1,284)	(9,600)					(135,705)	45

Facility Name & ID Number BRIAR PLACE LTD. # 0031765 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
see attached		see attached		see attached		
				GWH Limited Partnership		Building Company

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rent Expense	$ 942,530	GWH Limited Partnership	100.00%	$	$ (942,530)	1
2	V	32	Interest Expense		GWH Limited Partnership	100.00%	862,928	862,928	2
3	V	30	Depreciation		GWH Limited Partnership	100.00%	273,212	273,212	3
4	V	31	Amort - Organization Costs		GWH Limited Partnership	10.00%	280	280	4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 942,530			$ 1,136,420	$ * 193,890	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number BRIAR PLACE LTD. # 0031765 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	05	Utilities	$	Care Centers, Inc.	100.00%	$ 2,068	$ 2,068	15
16	V	06	Maintenance		Care Centers, Inc.	100.00%	4,045	4,045	16
17	V	10	Nursing	59	Care Centers, Inc.	100.00%	10	(49)	17
18	V	11	Activities		Care Centers, Inc.	100.00%	3	3	18
19	V	19	Professional Fees	320,820	Care Centers, Inc.	100.00%	12,048	(308,772)	19
20	V	20	Dues and Subscriptions	21,170	Care Centers, Inc.	100.00%	1,600	(19,570)	20
21	V	21	Office & Clerical		Care Centers, Inc.	100.00%	19,949	19,949	21
22	V	24	Travel and Seminar		Care Centers, Inc.	100.00%	1,190	1,190	22
23	V	26	Insurance		Care Centers, Inc.	100.00%	1,455	1,455	23
24	V	30	Depreciation		Care Centers, Inc.	100.00%	14,256	14,256	24
25	V	32	Interest		Care Centers, Inc.	100.00%	15,205	15,205	25
26	V	33	Real Estate Taxes		Care Centers, Inc.	100.00%	3,589	3,589	26
27	V	34	Rent - Building		Care Centers, Inc.	100.00%	5,544	5,544	27
28	V	35	Rent - Equipment & Auto		Care Centers, Inc.	100.00%	4,027	4,027	28
29	V	25	Bus Reimbursement	15,000	Care Centers, Inc.	100.00%		(15,000)	29
30	V	02	Food	178	Care Centers, Inc.	100.00%		(178)	30
31	V	17	Administration		Care Centers, Inc.	100.00%	487	487	31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 357,227			$ 85,476	$ * (271,751)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number BRIAR PLACE LTD. # 0031765 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	03	Housekeeping Salary	$	Care Centers, Inc.	100.00%	$	$	15
16	V	06	Maintenance Salary	4,131	Care Centers, Inc.	100.00%	4,131		16
17	V	07	Emp. Ben. - Gen. Serv.		Care Centers, Inc.	100.00%	544	544	17
18	V	10	Nursing Salary	70,377	Care Centers, Inc.	100.00%	65,744	(4,633)	18
19	V	10a	Rehab Salary	242	Care Centers, Inc.	100.00%	237	(5)	19
20	V	11	Activity Salary	4,317	Care Centers, Inc.	100.00%	4,341	24	20
21	V	12	Social Service Salary	39,387	Care Centers, Inc.	100.00%	39,387		21
22	V	15	Emp. Ben. - Healthcare		Care Centers, Inc.	100.00%	16,386	16,386	22
23	V	17	Administration Salary	80,919	Care Centers, Inc.	100.00%	80,940	21	23
24	V	21	Office Salary	26,787	Care Centers, Inc.	100.00%	26,787		24
25	V	27	Emp. Ben. - Gen. Admin.		Care Centers, Inc.	100.00%	16,472	16,472	25
26	V	22	Employee Benefits	30,194	Care Centers, Inc.	100.00%		(30,194)	26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 256,354			$ 254,969	$ * (1,385)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number BRIAR PLACE LTD. # 0031765 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	01	Dietary Salary	$ 8,468	Care Centers, Inc.	100.00%	$ 6,302	$ (2,166)	15
16	V	06	Maintenance Salary		Care Centers, Inc.	100.00%	2,393	2,393	16
17	V	07	Emp. Ben. - Gen. Serv.		Care Centers, Inc.	100.00%	1,175	1,175	17
18	V	10	Nursing Salary		Care Centers, Inc.	100.00%	14,828	14,828	18
19	V	12	Social Service Salary		Care Centers, Inc.	100.00%	17	17	19
20	V	15	Emp. Ben. - Healthcare		Care Centers, Inc.	100.00%	2,043	2,043	20
21	V	17	Administration Salary		Care Centers, Inc.	100.00%	41,424	41,424	21
22	V	21	Office Salary		Care Centers, Inc.	100.00%	118,277	118,277	22
23	V	27	Emp. Ben. - Gen. Admin.		Care Centers, Inc.	100.00%	22,499	22,499	23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 8,468			$ 208,958	$ * 200,490	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number BRIAR PLACE LTD. # 0031765 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	01	Dietary	$ 4,983	Care Centers, Inc. - Health Systems Division	100.00%	$ 538	$ (4,445)	15
16	V	02	Food		Care Centers, Inc. - Health Systems Division	100.00%	2,018	2,018	16
17	V	06	Maintenance		Care Centers, Inc. - Health Systems Division	100.00%	4	4	17
18	V	10	Nursing		Care Centers, Inc. - Health Systems Division	100.00%	3	3	18
19	V	17	Administration		Care Centers, Inc. - Health Systems Division	100.00%	68	68	19
20	V	19	Professional Fees		Care Centers, Inc. - Health Systems Division	100.00%	136	136	20
21	V	20	Dues & Subscriptions		Care Centers, Inc. - Health Systems Division	100.00%	7	7	21
22	V	21	Office & Clerical		Care Centers, Inc. - Health Systems Division	100.00%	98	98	22
23	V	24	Travel & Seminar		Care Centers, Inc. - Health Systems Division	100.00%	146	146	23
24	V	34	Rent - Building		Care Centers, Inc. - Health Systems Division	100.00%	4	4	24
25	V	35	Rent - Equipment & Auto		Care Centers, Inc. - Health Systems Division	100.00%	5	5	25
26	V	39	Ancillary Enteral Supplies	1,483	Care Centers, Inc. - Health Systems Division	100.00%	693	(790)	26
27	V	01	Dietary - Salary		Care Centers, Inc. - Health Systems Division	100.00%	1,289	1,289	27
28	V	07	Emp. Ben. - Gen. Serv.		Care Centers, Inc. - Health Systems Division	100.00%	173	173	28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 6,466			$ 5,182	$ * (1,284)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number BRIAR PLACE LTD. # 0031765 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	01	Dietary	$ 38,264	XCEL Medical Supply, LLC	100.00%	$ 33,080	$ (5,184)	15
16	V	03	Housekeeping	6,377	XCEL Medical Supply, LLC	100.00%	5,513	(864)	16
17	V	10	Nursing	26,218	XCEL Medical Supply, LLC	100.00%	22,666	(3,552)	17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 70,859			$ 61,259	$ * (9,600)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number BRIAR PLACE LTD. # 0031765 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	22	EMPLOYEE HEALTH INS.	$	CCS EMPLOYEE BENEFIT GROUP	100.00%	$ 109,889	$ 109,889	15
16	V								16
17	V								17
18	V								18
19	V	22	EMPLOYEE HEALTH INS.	109,889				(109,889)	19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 109,889			$ 109,889	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number BRIAR PLACE LTD. # 0031765 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number BRIAR PLACE LTD. # 0031765 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number BRIAR PLACE LTD. # 0031765 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number BRIAR PLACE LTD. # 0031765 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Eric Rothner	Owner	Administrative	31.43%	see attached	2.39	3.32%		$		1
2	Noah Wolff	Owner	Administrative	11.84%	see attached	12	28.58%				2
3	Mark Steinberg	Owner	Administrative	2.04%	see attached	2.44	4.88%	CCI alloc.	2,204	17-7	3
4	Melissa Rothner	Relative	Clerical		see attached			CCI alloc.	49	21-7	4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 2,253		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number BRIAR PLACE LTD. # 0031765 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number BRIAR PLACE LTD. # 0031765 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Care Centers, Inc.
Street Address: 2202 West Main Street
City / State / Zip Code: Evanston, Illinois 60202
Phone Number: (847) 905-3000
Fax Number: (847) 905-3030

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	05	Utilities	Patient Days	1,640,756	39	$ 42,470	$	79,893	$ 2,068	1
2	06	Maintenance	Patient Days	1,640,756	39	83,080		79,893	4,045	2
3	10	Nursing	Patient Days	1,640,756	39	205		79,893	10	3
4	11	Activities	Patient Days	1,640,756	39	51		79,893	3	4
5	19	Professional Fees	Patient Days	1,640,756	39	247,437		79,893	12,048	5
6	20	Dues and Subscriptions	Patient Days	1,640,756	39	32,863		79,893	1,600	6
7	21	Office & Clerical	Patient Days	1,640,756	39	409,698		79,893	19,949	7
8	24	Travel and Seminar	Patient Days	1,640,756	39	53,743		79,893	1,190	8
9	26	Insurance	Patient Days	1,640,756	39	29,875		79,893	1,455	9
10	30	Depreciation	Patient Days	1,640,756	39	292,776		79,893	14,256	10
11	32	Interest	Patient Days	1,640,756	39	312,254		79,893	15,205	11
12	33	Real Estate Taxes	Patient Days	1,640,756	39	73,702		79,893	3,589	12
13	34	Rent - Building	Patient Days	1,640,756	39	113,857		79,893	5,544	13
14	35	Rent - Equipment & Auto	Patient Days	1,640,756	39	82,710		79,893	4,027	14
15	17	Administration	Patient Days	1,640,756	39	10,000		79,893	487	15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,784,721	$		$ 85,476	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number BRIAR PLACE LTD. # 0031765 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Care Centers, Inc.
Street Address: 2202 West Main Street
City / State / Zip Code: Evanston, Illinois 60202
Phone Number: (847) 905-3000
Fax Number: (847) 905-3030

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	03	Housekeeping Salary	Direct Cost			45,667	45,667			1
2	06	Maintenance Salary	Direct Cost			169,934	169,934		4,131	2
3	07	Emp. Ben. - Gen. Serv.	Direct Cost			29,646			544	3
4	10	Nursing Salary	Direct Cost			895,582	895,582		65,744	4
5	10a	Rehab Salary	Direct Cost			128,376	128,376		237	5
6	11	Activity Salary	Direct Cost			57,201	57,201		4,341	6
7	12	Social Service Salary	Direct Cost			219,790	219,790		39,387	7
8	15	Emp. Ben. - Healthcare	Direct Cost			180,204			16,386	8
9	17	Administration Salary	Direct Cost			1,334,207	1,334,207		80,940	9
10	21	Office Salary	Direct Cost			584,278	584,278		26,787	10
11	27	Emp. Ben. - Gen. Admin.	Direct Cost			267,060			16,472	11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 3,911,943	$ 3,435,033		$ 254,969	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number BRIAR PLACE LTD. # 0031765 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Care Centers, Inc.
Street Address: 2202 West Main Street
City / State / Zip Code: Evanston, Illinois 60202
Phone Number: (847) 905-3000
Fax Number: (847) 905-3030

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	01	Dietary Salary	Patient Days	1,640,756	39	129,417	129,417	79,893	6,302	1
2	06	Maintenance Salary	Patient Days	1,640,756	39	49,148	49,148	79,893	2,393	2
3	07	Emp. Ben. - Gen. Serv.	Patient Days	1,640,756	39	24,132		79,893	1,175	3
4	10	Nursing Salary	Patient Days	1,640,756	39	304,530	304,530	79,893	14,828	4
5	12	Social Service Salary	Patient Days	1,640,756	39	354	354	79,893	17	5
6	15	Emp. Ben. - Healthcare	Patient Days	1,640,756	39	41,952		79,893	2,043	6
7	17	Administration Salary	Patient Days	1,640,756	39	850,731	850,731	79,893	41,424	7
8	21	Office Salary	Patient Days	1,640,756	39	2,429,052	2,429,052	79,893	118,277	8
9	27	Emp. Ben. - Gen. Admin.	Patient Days	1,640,756	39	462,069		79,893	22,499	9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 4,291,386	$ 3,763,233		$ 208,958	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number BRIAR PLACE LTD. # 0031765 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Care Centers, Inc.
Street Address: 2202 West Main Street
City / State / Zip Code: Evanston, Illinois 60202
Phone Number: (847) 905-3000
Fax Number: (847) 905-3030

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	01	Dietary	Billable Income	2,191,458		182,448		6,466	538	1
2	02	Food	Billable Income	2,191,458		834,365		6,466	2,018	2
3	06	Maintenance	Billable Income	2,191,458		1,400		6,466	4	3
4	10	Nursing	Billable Income	2,191,458		850		6,466	3	4
5	17	Administration	Billable Income	2,191,458		23,000		6,466	68	5
6	19	Professional Fees	Billable Income	2,191,458		46,205		6,466	136	6
7	20	Dues & Subscriptions	Billable Income	2,191,458		2,514		6,466	7	7
8	21	Office & Clerical	Billable Income	2,191,458		33,124		6,466	98	8
9	24	Travel & Seminar	Billable Income	2,191,458		49,456		6,466	146	9
10	34	Rent - Building	Billable Income	2,191,458		1,300		6,466	4	10
11	35	Rent - Equipment & Auto	Billable Income	2,191,458		1,830		6,466	5	11
12	39	Ancillary Enteral Supplies	Billable Income	2,191,458		84,436		6,466	693	12
13	01	Dietary - Salary	Billable Income	2,191,458		436,887	436,887	6,466	1,289	13
14	07	Emp. Ben. - Gen. Serv.	Billable Income	2,191,458		58,714		6,466	173	14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,756,530	$ 436,887		$ 5,182	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number BRIAR PLACE LTD. # 0031765 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Xcel Medical Supply, LLC
Street Address: 2201 Main Street
City / State / Zip Code: Evanston, IL 60202
Phone Number: ((847) 328-7600
Fax Number: ((847) 328-7615

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	01	Dietary	Direct Allocation			$	$		$ 33,080	1
2	03	Housekeeping	Direct Allocation						5,513	2
3	10	Nursing	Direct Allocation						22,666	3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 61,259	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number BRIAR PLACE LTD. # 0031765 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: CCS EMPLOYEE BENEFITS GROUP, INC.
Street Address: 2201 W. MAIN ST.
City / State / Zip Code: EVANSTON, IL 60202
Phone Number: (847) 905-4000
Fax Number: (847) 905-4040

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	22	EMPLOYEE HEALTH INS.	DIRECT ALLOCATION			$	$		$ 109,889	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 109,889	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number BRIAR PLACE LTD. # 0031765 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number BRIAR PLACE LTD. # 0031765 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number BRIAR PLACE LTD. # 0031765 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number BRIAR PLACE LTD. # 0031765 Report Period Beginning: 01/01/02 Ending: 12/31/02

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	White Oak Nursing Center		X	Mortgage	$78,544.00	03/01/97	$ 7,441,383	$ 7,033,761	11/01/21	12.00%	$ 849,242	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Diawa	X		Working Capital							5,328	6
7												7
8												8
9	TOTAL Facility Related				$78,544.00		$ 7,441,383	$ 7,033,761			$ 854,570	9
	B. Non-Facility Related*											
10	See Supplemental Schedule										9,222	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ 9,222	14
15	TOTALS (line 9+line14)						$ 7,441,383	$ 7,033,761			$ 863,792	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ N/A Line # _____

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number BRIAR PLACE LTD. # 0031765 Report Period Beginning: 01/01/02 Ending: 12/31/02

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
1	Shareholder Interest (Bldg Co)						$	$			$ 13,687	1
2	Interest Income										(19,670)	2
3	Care Centers allocation										15,205	3
4												4
5												5
6												6
7												7
8												8
9												9
10												10
11												11
12												12
13												13
14												14
15												15
16												16
17												17
18												18
19												19
20												20
21							$	$			$ 9,222	21

Facility Name & ID Number BRIAR PLACE LTD. # 0031765 Report Period Beginning: 01/01/02 Ending: 12/31/02

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2001 report.	$	275,100	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	291,817	2
3. Under or (over) accrual (line 2 minus line 1).	$	16,717	3
4. Real Estate Tax accrual used for 2002 report. (Detail and explain your calculation of this accrual on the lines below.)	$	302,600	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	319,317	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1997	261,872	8
	1998	256,204	9
	1999	247,528	10
	2000	261,097	11
	2001	288,228	12

2002 accrual = 2001 tax + 5% ($288,228 x 105% = $302,600 rounded)

Care Centers allocation $3589

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2001	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2001 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2001 real estate tax costs, as well as copies of your real estate tax bills for calendar 2001.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2001 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2002 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2001 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME BRIAR PLACE LTD. COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0031765

CONTACT PERSON REGARDING THIS REPORT STEVEN LAVENDA

TELEPHONE (847) 236-1111 FAX #: (847) 236-1155

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2001 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2001.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	18-20-102-035-0000	Nursing Home	$ 288,227.86	$ 288,227.86
2.	see attached	Home office allocation	$ 70,261.69	$ 3,421.24
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 358,489.55	$ 291,649.10

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? X YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2001 tax bills which were listed in Section A to this statement. Be sure to use the 2001 tax bill which is normally paid during 2002.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME BRIAR PLACE LTD. COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0031765

CONTACT PERSON REGARDING THIS REPORT _____

TELEPHONE ( ) _____ FAX #: ( ) _____

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

Facility Name & ID Number BRIAR PLACE LTD. # 0031765 Report Period Beginning: 01/01/02 Ending: 12/31/02

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 65,200 B. General Construction Type: Exterior Brick Frame _____ Number of Stories 5

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [X] YES [ ] NO
If so, please complete the following:

1. Total Amount Incurred: 12,468
2. Number of Years Over Which it is Being Amortized: _____
3. Current Period Amortization: 4,190
4. Dates Incurred: _____

Nature of Costs: Financing Fees, Organization Costs
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility		1997	$ 402,069	1
2	Care Centers allocation			20,480	2
3	TOTALS			$ 422,549	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number BRIAR PLACE LTD. # 0031765 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1986	5,000		20	263	263	4,241	9
10	Various			1987	138,915		20	7,310	7,310	114,527	10
11	Various			1988	9,885		20	519	519	7,639	11
12	Various			1989	5,410		20	264	264	3,520	12
13	Various			1990	42,578		20	2,130	2,130	26,747	13
14	Various			1991	11,813		20	591	591	6,995	14
15	Various			1992	11,426		20	571	571	5,900	15
16	Various			1993	8,851		20	443	443	5,952	16
17	Various			1994	25,632		20	1,282	1,282	10,597	17
18	Various			1995	50,028		20	2,502	2,502	18,883	18
19	Various			1996	161,111		20	8,053	8,053	47,647	19
20	Various			1997	165,320		20	8,266	8,266	48,165	20
21	Various			1998	185,999		20	9,301	9,301	42,864	21
22								-		-	22
23								-		-	23
24								-		-	24
25								-		-	25
26								-		-	26
27								-		-	27
28								-		-	28
29								-		-	29
30								-		-	30
31								-		-	31
32								-		-	32
33								-		-	33
34								-		-	34
35								-		-	35
36								-		-	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number BRIAR PLACE LTD. # 0031765 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$ -	$	$ -	37
38						-		-	38
39						-		-	39
40						-		-	40
41						-		-	41
42						-		-	42
43						-		-	43
44						-		-	44
45						-		-	45
46						-		-	46
47						-		-	47
48						-		-	48
49						-		-	49
50						-		-	50
51						-		-	51
52						-		-	52
53						-		-	53
54						-		-	54
55						-		-	55
56						-		-	56
57						-		-	57
58						-		-	58
59						-		-	59
60						-		-	60
61						-		-	61
62						-		-	62
63						-		-	63
64						-		-	64
65						-		-	65
66						-		-	66
67						-		-	67
68	Related Party Allocations (Page 12-REP & Page 12A-REP)		7,095,896	166,738		185,591	18,853	1,069,239	68
69	Financial Statement Depreciation			43,343			(43,343)		69
70	TOTAL (lines 4 thru 69)		$ 7,917,864	$ 210,081		$ 227,086	$ 17,005	$ 1,412,916	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number BRIAR PLACE LTD. # 0031765 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 7,917,864	$ 210,081		$ 227,086	$ 17,005	$ 1,412,916	1
2	HINGES	1999	1,907		20	95	95	372	2
3	CORNER GUARDS	1999	891		20	45	45	173	3
4	HVAC	1999	688		20	18	18	65	4
5	RECEIVER SYSTEM	1999	2,143		20	107	107	383	5
6	SPRINKLER	1999	2,240		20	112	112	401	6
7	HVAC	1999	1,065		20	53	53	190	7
8	HVAC	1999	953		20	48	48	164	8
9	HVAC	1999	1,341		20	67	67	229	9
10	WATERPROOF SVCS	1999	900		20	45	45	154	10
11	HVAC RENOVATION	1999	658		20	33	33	110	11
12	FAUCETS	1999	1,009		20	50	50	171	12
13	POWER FOR TOASTER	1999	660		20	33	33	113	13
14	WATER HEATERS	1999	7,485		20	374	374	1,247	14
15	MOTOR WORK	1999	1,243		20	62	62	202	15
16	BRASS/CHROME HANDLES	1999	696		20	35	35	140	16
17	HVAC	2000	511		20	26	26	78	17
18	HVAC	2000	679		20	34	34	102	18
19	CIRCUIT BREAKERS	2000	580		20	29	29	87	19
20	BOILER REPAIRS	2000	975		20	49	49	147	20
21	HVAC	2000	1,043		20	52	52	152	21
22	PLUMBING REPAIR	2000	701		20	35	35	102	22
23	PAINTING	2000	1,286		20	64	64	187	23
24	PLUMBING REPAIR	2000	506		20	25	25	73	24
25	PLUMBING	2000	1,006		20	50	50	133	25
26	TANK & PUMP	2000	10,225		20	511	511	1,363	26
27	HVAC	2000	534		20	27	27	70	27
28	HVAC	2000	3,829		20	191	191	493	28
29	HVAC	2000	524		20	26	26	65	29
30	CONDENSOR	2000	505		20	25	25	63	30
31	DRAIN	2000	887		20	44	44	110	31
32	HVAC	2000	857		20	43	43	104	32
33	HVAC	2000	2,285		20	114	114	266	33
34	TOTAL (lines 1 thru 33)		$ 7,968,676	$ 210,081		$ 229,608	$ 19,527	$ 1,420,625	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number BRIAR PLACE LTD. # 0031765 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 7,968,676	$ 210,081		$ 229,608	$ 19,527	$ 1,420,625	1
2	CONCRETE PATIO	2000	6,233		20	312	312	728	2
3	PLUMBING	2000	6,300		20	315	315	735	3
4	HVAC	2000	1,069		20	53	53	119	4
5	ELEVATOR	2000	50,875		20	2,544	2,544	5,724	5
6	WATER HEATER	2000	7,450		20	373	373	839	6
7	REWIRE SPEAKERS	2000	898		20	45	45	101	7
8	HVAC	2000	559		20	56	56	121	8
9	CUBICLE CURTAINS	2000	1,108		20	55	55	160	9
10	PLY PANELS	2000	809		20	40	40	110	10
11	LINEN CHUTE	2000	1,290		20	65	65	179	11
12	WINDOW REPAIR	2000	664		20	33	33	91	12
13	RAIN VENT CAP	2000	618		20	31	31	83	13
14	EXHAUST FAN	2000	1,900		20	95	95	253	14
15	DOORS	2000	614		20	31	31	83	15
16	DOOR	2000	827		20	41	41	106	16
17	CABINETS	2000	712		20	36	36	93	17
18	WINDOWS	2000	679		20	34	34	85	18
19	CABLE	2000	3,176		20	159	159	384	19
20	CIRCUIT	2000	2,500		20	125	125	302	20
21	DOOR CLOSER	2000	917		20	46	46	111	21
22	THERMOSTAT-ETC.	2000	1,737		20	87	87	203	22
23	FLOOD LIGHTS	2000	792		20	40	40	90	23
24	RELAY BOARD	2000	1,676		20	84	84	189	24
25	ALARM	2000	814		20	41	41	99	25
26	ELEVATOR DOOE OPENER	2000	1,185		20	59	59	143	26
27	FLOOD LIGHT	2000	510		20	26	26	61	27
28	ELEVATOR ELEC	2001	7,450		20	373	373	746	28
29	HVAC	2001	1,792		20	90	90	173	29
30	CABLE JACKS	2001	723		20	36	36	66	30
31	CABINETS	2001	753		20	38	38	67	31
32	GAS HOSE	2001	543		20	27	27	47	32
33	PUMP	2001	760		20	38	38	63	33
34	TOTAL (lines 1 thru 33)		$ 8,076,609	$ 210,081		$ 235,036	$ 24,955	$ 1,432,979	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number BRIAR PLACE LTD. # 0031765 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 8,076,609	$ 210,081		$ 235,036	$ 24,955	$ 1,432,979	1
2	PAIN	2001	789		20	39	39	62	2
3	DRIANS	2001	567		20	28	28	44	3
4	SPRINKLER HEADS	2001	1,130		20	57	57	90	4
5	MOTOR	2001	721		20	36	36	57	5
6	PAINT	2001	681		20	34	34	51	6
7	PAINT	2001	1,199		20	60	60	85	7
8	PAINT	2001	1,006		20	50	50	71	8
9	ALARM REPAIR	2001	537		20	27	27	38	9
10	FIRE ALARM	2001	1,425		20	71	71	101	10
11	FIRE ALARM	2001	1,425		20	71	71	101	11
12	GAS PIPE	2001	725		20	36	36	48	12
13	FIRE ALARM	2001	1,425		20	71	71	95	13
14	PLUMBING	2001	660		20	33	33	41	14
15	TILING	2001	4,172		20	209	209	261	15
16	PLUMBING	2001	509		20	25	25	31	16
17	PLUMBING	2001	643		20	32	32	40	17
18	MASONRY	2001	3,000		20	150	150	175	18
19	HAND RAIL	2001	1,624		20	81	81	95	19
20	EJECTOR PUMP	2001	3,275		20	164	164	191	20
21	CODE ALERT	2001	(1,676)		20	(84)	(84)	(98)	21
22	ANTENNAS	2001	1,340		20	67	67	128	22
23	DOOR CLOSERS	2001	565		20	28	28	56	23
24	ROOFING	2001	500		20	25	25	48	24
25	FAUCET	2001	573		20	29	29	56	25
26	CONTROL UNIT	2001	503		20	25	25	50	26
27	CONTROL UNIT	2001	1,353		20	68	68	130	27
28	DEVICE FOR ELEVATOR	2001	2,000		20	100	100	192	28
29	ALARM DEVICE	2001	2,475		20	124	124	227	29
30	KEYPAD	2001	685		20	34	34	62	30
31	TILE	2001	1,681		20	84	84	126	31
32	VALVES	2001	1,605		20	80	80	113	32
33	PAINT	2001	1,282		20	64	64	85	33
34	TOTAL (lines 1 thru 33)		$ 8,115,008	$ 210,081		$ 236,954	$ 26,873	$ 1,435,831	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number BRIAR PLACE LTD. # 0031765 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		$ 8,115,008	$ 210,081		$ 236,954	$ 26,873	$ 1,435,831	1
2	ID CONSOLE	2001	676		20	34	34	45	2
3	TRANSFORMER	2002	644		20	92	92	92	3
4	COOLER DOOR	2002	1,850		20	41	41	41	4
5	P A AMPLIFIER	2002	690		20	25	25	25	5
6	WALK IN FREEZER REPAIR	2002	607		20	14	14	14	6
7	SPRINKLER SYSTEM	2002	2,000		20	200	200	200	7
8	PAINT	2002	678		20	678	678	678	8
9	TUCKPOINTING	2002	5,100		20	510	510	510	9
10	DOOR CLOSERS	2002	3,270		20	327	327	327	10
11	SMOKE DAMPER	2002	3,520		20	293	293	293	11
12	PROGRAM ALARM	2002	874		20	125	125	125	12
13	FIRE SAFETY EVAL	2002	2,919		20	382	382	382	13
14	ROOF MAINTENANCE	2002	3,650		20	335	335	335	14
15	FLOORING	2002	2,874		20	176	176	176	15
16	PLUMBING REPAIR	2002	766		20	64	64	64	16
17	PLUMBING REPAIR	2002	613		20	46	46	46	17
18	ROD OUT SEWER	2002	860		20	57	57	57	18
19	PLUMBING	2002	603		20	25	25	25	19
20	PAINT	2002	557		20	139	139	139	20
21	PLUMBING	2002	603		20	15	15	15	21
22	WINDOWS	2002	36,000		20	900	900	900	22
23	PAINT	2002	828		20	138	138	138	23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 8,185,190	$ 210,081		$ 241,570	$ 31,489	$ 1,440,458	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number BRIAR PLACE LTD. # 0031765 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		$ 8,185,190	$ 210,081		$ 241,570	$ 31,489	$ 1,440,458	1
2									2
3									3
4									4
5									5
6									6
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29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 8,185,190	$ 210,081		$ 241,570	$ 31,489	$ 1,440,458	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number BRIAR PLACE LTD. # 0031765 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		$ 8,185,190	$ 210,081		$ 241,570	$ 31,489	$ 1,440,458	1
2									2
3									3
4									4
5									5
6									6
7									7
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9									9
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11									11
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29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 8,185,190	$ 210,081		$ 241,570	$ 31,489	$ 1,440,458	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number BRIAR PLACE LTD. # 0031765 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12G, Carried Forward		$ 8,185,190	$ 210,081		$ 241,570	$ 31,489	$ 1,440,458	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
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27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 8,185,190	$ 210,081		$ 241,570	$ 31,489	$ 1,440,458	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number BRIAR PLACE LTD. # 0031765 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		$ 8,185,190	$ 210,081		$ 241,570	$ 31,489	$ 1,440,458	1
2									2
3									3
4									4
5									5
6									6
7									7
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29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 8,185,190	$ 210,081		$ 241,570	$ 31,489	$ 1,440,458	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number BRIAR PLACE LTD. # 0031765 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12I, Carried Forward		$ 8,185,190	$ 210,081		$ 241,570	$ 31,489	$ 1,440,458	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
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29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 8,185,190	$ 210,081		$ 241,570	$ 31,489	$ 1,440,458	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number BRIAR PLACE LTD. # 0031765 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12I, Carried Forward		$ 8,185,190	$ 210,081		$ 241,570	$ 31,489	$ 1,440,458	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
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30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 8,185,190	$ 210,081		$ 241,570	$ 31,489	$ 1,440,458	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number BRIAR PLACE LTD. # 0031765 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4			1997		$ 7,041,541	$ 164,470	39	$ 183,266	$ 18,796	$ 1,069,052	4
5	CCI allocation		1996			1,296	35	1,444	148		5
6	CCI allocation		2002		28,223	53	35	78	25	78	6
7											7
8											8
	Improvement Type**										
9	Care Centers allocation			2002		481	20	32	(449)		9
10	Care Centers allocation			2001		1	20	7	6		10
11	Care Centers allocation			2000		2	20	3	1		11
12	Care Centers allocation			1999		23	20	45	(22)		12
13	Care Centers allocation			1998		10	20	19	9		13
14	Care Centers allocation			1997		93	20	187	94		14
15	Care Centers allocation			1996		242	20	370	128		15
16	Care Centers allocation			1997		1	20	31	30		16
17	Care Centers allocation			1994		12	20		(12)		17
18	Care Centers allocation			1993		5	20		(5)		18
19	Care Centers allocation			2002	26,132	49	20	109	60	109	19
20											20
21											21
22											22
23											23
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28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A-REP, Line 70 for total

Facility Name & ID Number BRIAR PLACE LTD. # 0031765 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
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62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 7,095,896	$ 166,738		$ 185,591	$ 18,809	$ 1,069,239	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number BRIAR PLACE LTD. # 0031765 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 1,201,580	$ 195,636	$ 112,610	$ (83,026)	10	$ 686,079	71
72	Current Year Purchases	48,606	1,810	9,922	8,112	10	9,922	72
73	Fully Depreciated Assets	153,101				10	153,101	73
74								74
75	TOTALS	$ 1,403,287	$ 197,446	$ 122,532	$ (74,914)		$ 849,102	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76		1993 FORD VAN	1993	$ 47,239	$ 2,030	$ 3,099	$ 1,069	5	$ 29,699	76
77		CHICAGO BUS SALES	2001	4,439	1,420	444	(976)	5	703	77
78		TAIL PIPE	2001	1,154	369	115	(254)	5	153	78
79		CCI ALLOCATION		32,802	5,518	4,781	(737)	5	17,938	79
80	TOTALS			$ 85,634	$ 9,337	$ 8,439	$ (898)		$ 48,493	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$	10,096,660	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$	416,864	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$	372,541	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	(44,323)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$	2,338,053	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number BRIAR PLACE LTD. # 0031765 Report Period Beginning: 01/01/02 Ending: 12/31/02

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5	Care Centers allocation				5,544			5
6	Care Centers Health Systems allocation				4			6
7	TOTAL				$ 5,548 **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2003	$
13.	/2004	$
14.	/2005	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: $ 12,931 Description: see attached
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number BRIAR PLACE LTD. # 0031765 Report Period Beginning: 01/01/02 Ending: 12/31/02

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

			1	2	3	4
			Facility			
			Drop-outs	Completed	Contract	Total
1	Community College Tuition		$	$	$	$
2	Books and Supplies					
3	Classroom Wages	(a)				
4	Clinical Wages	(b)				
5	In-House Trainer Wages	(c)				
6	Transportation					
7	Contractual Payments					
8	Nurse Aide Competency Tests					
9	TOTALS		$	$	$	$
10	SUM OF line 9, col. 1 and 2	(e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

SEE ACCOUNTANTS' COMPILATION REPORT

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39 - 03	hrs	$		$ 48,161	$		$ 48,161	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			51,118			51,118	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			48,080			48,080	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 02	# of prescrpts				39,989		39,989	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): See Supplemental						15,660		15,660	13
14	TOTAL			$		$ 147,359	$ 55,649		$ 203,008	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number BRIAR PLACE LTD. # 0031765 Report Period Beginning: 01/01/02 Ending: 12/31/02

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/02 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 1,772	$ 1,772	1
2	Cash-Patient Deposits	63,023	63,023	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,286,424	1,286,424	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	336,286	336,286	6
7	Other Prepaid Expenses	11,365	11,365	7
8	Accounts Receivable (owners or related parties)	71,924	71,924	8
9	Other(specify): See Supplemental Schedule	1,028,165	1,028,165	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,798,959	$ 2,798,959	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		402,069	13
14	Buildings, at Historical Cost		6,414,314	14
15	Leasehold Improvements, at Historical Cost	1,016,264	1,016,264	15
16	Equipment, at Historical Cost	892,011	2,117,011	16
17	Accumulated Depreciation (book methods)	(985,710)	(2,991,091)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		8,391	19
20	Accumulated Amortization - Organization & Pre-Operating Costs		(8,391)	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See Supplemental Schedule	679	679	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 923,244	$ 6,959,246	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 3,722,203	$ 9,758,205	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 1,185,329	$ 1,325,101	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	62,617	62,617	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	234,351	234,351	30
31	Accrued Taxes Payable (excluding real estate taxes)	26,921	26,921	31
32	Accrued Real Estate Taxes(Sch.IX-B)	302,600	302,600	32
33	Accrued Interest Payable		70,981	33
34	Deferred Compensation	1,492	1,492	34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Supplemental Schedule	32,016	98,881	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,845,326	$ 2,122,944	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		7,033,761	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Supplemental Schedule			43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$ 7,033,761	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,845,326	$ 9,156,705	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,876,877	$ 601,500	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 3,722,203	$ 9,758,205	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Facility Name & ID Number BRIAR PLACE LTD. # 0031765 Report Period Beginning: 01/01/02 Ending: 12/31/02

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$ 727,965	1	
2	Restatements (describe):		2	
3	Late journal entry - State Replacement Tax	(7,500)	3	
4			4	
5			5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 720,465	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	1,352,412	7	
8	Aquisitions of Pooled Companies		8	
9	Proceeds from Sale of Stock		9	
10	Stock Options Exercised		10	
11	Contributions and Grants		11	
12	Expenditures for Specific Purposes		12	
13	Dividends Paid or Other Distributions to Owners	(196,000)	13	
14	Donated Property, Plant, and Equipment		14	
15	Other (describe)		15	
16	Other (describe)		16	
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 1,156,412	17	
	B. Transfers (Itemize):			
18			18	
19			19	
20			20	
21			21	
22			22	
23	**TOTAL Transfers (sum of lines 18-22)**	$	23	
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 1,876,877	24	*

*** This must agree with page 17, line 47.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number BRIAR PLACE LTD. # 0031765 Report Period Beginning: 01/01/02 Ending: 12/31/02

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 8,925,946	1
2	Discounts and Allowances for all Levels	(735,618)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 8,190,328	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	526,819	6
7	Oxygen	(230)	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 526,589	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	155,039	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	4,887	19
20	Radiology and X-Ray	740	20
21	Other Medical Services	33,183	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 193,849	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	19,670	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 19,670	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	73,306	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 73,306	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 9,003,742	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,520,367	31
32	Health Care	2,717,989	32
33	General Administration	1,645,139	33
	B. Capital Expense		
34	Ownership	1,405,791	34
	C. Ancillary Expense		
35	Special Cost Centers	203,008	35
36	Provider Participation Fee	159,036	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 7,651,330	40
41	**Income before Income Taxes (line 30 minus line 40)****	1,352,412	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 1,352,412	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? not complete If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation. SEE ACCOUNTANTS' COMPILATION REPORT**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number BRIAR PLACE LTD. # 0031765 Report Period Beginning: 01/01/02 Ending: 12/31/02

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing			$	$	1
2	Assistant Director of Nursing	1,721	2,042	57,533	28.17	2
3	Registered Nurses	12,687	14,566	334,924	22.99	3
4	Licensed Practical Nurses	26,787	31,894	669,412	20.99	4
5	Nurse Aides & Orderlies	74,068	86,191	788,507	9.15	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	5,269	5,967	86,207	14.45	8
9	Activity Director	1,897	2,103	24,387	11.60	9
10	Activity Assistants	12,120	13,137	101,568	7.73	10
11	Social Service Workers	18,527	20,866	241,839	11.59	11
12	Dietician					12
13	Food Service Supervisor	3,529	4,084	64,899	15.89	13
14	Head Cook					14
15	Cook Helpers/Assistants	27,893	30,743	255,498	8.31	15
16	Dishwashers					16
17	Maintenance Workers	15,334	16,703	176,392	10.56	17
18	Housekeepers	23,791	26,283	206,120	7.84	18
19	Laundry	10,000	11,116	90,809	8.17	19
20	Administrator					20
21	Assistant Administrator	816	993	26,544	26.73	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	4,689	5,426	54,747	10.09	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,978	2,356	30,551	12.97	31
32	Other Health Care(specify)					32
33	Other(specify) See Supplemental	4,327	4,556	47,834	10.50	33
34	TOTAL (lines 1 - 33)	245,433	279,026	$ 3,257,771 *	$ 11.68	34

SEE ACCOUNTANTS' COMPILATION REPORT

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	234	$ 11,061	01-03	35
36	Medical Director	monthly	8,250	09-03	36
37	Medical Records Consultant	monthly	722	10-03	37
38	Nurse Consultant				38
39	Pharmacist Consultant	monthly	1,550	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	35	1,656	11-03	44
45	Social Service Consultant				45
46	Other(specify)				46
47	UR Committee		150	10-3	47
48	CCI - see attached		122,791		48
49	TOTAL (lines 35 - 48)	269	$ 146,180		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	15	$ 768	10-03	50
51	Licensed Practical Nurses	695	26,170	10-03	51
52	Nurse Aides	133	3,412	10-03	52
53	TOTAL (lines 50 - 52)	843	$ 30,350		53

Facility Name & ID Number BRIAR PLACE LTD. # 0031765 Report Period Beginning: 01/01/02 Ending: 12/31/02

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Bonzetta Willliams	Asst, Admin.	0	$ 26,544
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 26,544

B. Administrative - Other

Description	Amount
CCI Administrative Payroll	$ 79,643
TOTAL (agree to Schedule V, line 17, col. 3)	$ 79,643
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Cindy Zola	IOC Consulting	$ 370
Maxxsource	Computer Package	1,100
Sourcetech	Computer Support	815
Omnicare	Computer Support	900
Personnel Planners	Unemployment Consult	3,146
Alpha Data	Data Processing	4,796
Automall of America	Computer Support	80
Care Centers, Inc.	various - see attached	320,820
Various - see attached	Legal	3,661
Various - see attached	Accounting	18,449
Teg Services	Utility Mgmt Services	225
National Hotline	Compliance Phone Service	187
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 354,549

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 121,351
Unemployment Compensation Insurance	34,585
FICA Taxes	249,137
Employee Health Insurance	148,382
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Pension Expense	6,409
Misc Employee Welfare	10,696
Employee Physicals	6,795
TOTAL (agree to Schedule V, line 22, col.8)	$ 577,355

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 200
Advertising: Employee Recruitment	30,321
Health Care Worker Background Check	1,500
(Indicate # of checks performed 125)	
Dues & Subscriptions	8,841
Licenses & Fees	4,965
Advertising & Promotion	36,131
Yellow Page Advertising	3,172
Care Centers allocation	1,600
Care Centers Health Systems alloc.	7
Less: Public Relations Expense	( )
Non-allowable advertising	(36,131)
Yellow page advertising	(3,172)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 47,434

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	845
Care Centers allocation	1,190
Care Centers Health Systems alloc.	146
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 2,181

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number BRIAR PLACE LTD. # 0031765 Report Period Beginning: 01/01/02 Ending: 12/31/02

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007
1	N/A		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number BRIAR PLACE LTD. # 0031765 Report Period Beginning: 01/01/02 Ending: 12/31/02

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **ICLTC $11108**

(3) Did the nursing home make political contributions or payments to a political action organization? **Yes** If YES, have these costs been properly adjusted out of the cost report? **Yes**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **10 yrs**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **1,845** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **127,020**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ Has any meal income been offset against related costs? **No** Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **None**
d. Have vehicle usage logs been maintained? **Yes**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **Yes**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees